

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in an event within 72 hours after death.

VS. A15ME
5M 7/59

11427
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
11599

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Swanton				c. LENGTH OF STAY IN 1b Swanton			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS Swanton			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle E. Last Beeman				4. DATE OF DEATH Month Oct. Day 23rd. Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 17, 1898	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Gilmore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Graham				14. MOTHER'S MAIDEN NAME Lulu Alexander			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Fred Beeman Address Swanton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute 420.1 DUE TO Hypertensive cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Sudden Years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 10-23-60				Address (Street, city, town, or county) Oakland, Md.			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE TIME OF 10/26/60		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, Md	
23. FUNERAL DIRECTOR George Eichhorn ADDRESS Lonaconing, Md.				24a. REC'D BY REGISTRAR DATE OCT 27 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>	

MEDICAL CERTIFICATION

RECEIVED
MAY 1917



11137
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
STATE OF NEW YORK
COUNTY OF NEW YORK

Deceased: William
Age: 35
Sex: Male
Race: White
Birthplace: England
Residence: London

Signature of Deceased: William
Signature of Medical Examiner: Thomas Graham
Date: June 17, 1917
Place: London, England
Cause of Death: U.S.A.
Signature of Coroner: John Alexander
Signature of Medical Examiner: John Beaman
Signature of Coroner: John Beaman

Signature of Coroner: John Beaman
Signature of Medical Examiner: John Beaman
Signature of Coroner: John Beaman
Signature of Medical Examiner: John Beaman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
11428

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11400

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Moscow</u>		c. LENGTH OF STAY IN 1b <u>6 Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2 Mi. W. Moscow</u>		d. STREET ADDRESS <u>2 Mi. W. Moscow</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma Adeline Boal</u>		4. DATE OF DEATH Month Day Year <u>Oct. 26 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1912</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bruce Wilt</u>		14. MOTHER'S MAIDEN NAME <u>Mary Norris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Ellis Boal-R.D. 1, Barton, Md.</u>	
17. INFORMANT <u>Ellis Boal-R.D. 1, Barton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> <u>5 Years</u> <u>5 Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 26 1960</u> to <u>Oct 26 1960</u> , that (I) (we) last saw the deceased <u>dead</u> on <u>Oct 26 1960</u> , and that death occurred at <u>5:10</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul R. Wilson</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Paul R. Wilson M.D.</u>		22d. ADDRESS <u>Piedmont W.Va</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/28/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Moscow Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ex. Boal</u>		25a. REC'D BY REGISTRAR <u>Oct 28 '60</u>	
ADDRESS <u>Westernport, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

11-28

1

Wm.

Oct. 20, 1910

Paul R. Wilson

Oct. 18, 1910

Wm. R. Wilson

2000 10 10

10 10 10

10 10 10

10 10 10

10 10 10

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11429
11401
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Garrett STATE Maryland.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Crellin		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Crellin	
c. LENGTH OF STAY IN 1b 57 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 Mi. West of Crellin		d. STREET ADDRESS 1 Mi. West of Crellin	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle Franklin Last Bowman		4. DATE OF DEATH Month October Day 3 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1903
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 5 Days 10 Hours 10 Min.	IF UNDER 24 HRS. Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel F. Bowman		14. MOTHER'S MAIDEN NAME Effie Enlow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-10-2915	
17. INFORMANT Mrs. David Bowman		Address Crellin, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 416X IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Chronic Myocardial Insufficiency DUE TO (c) Rheumatic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 5 minutes 5 years 25 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1957 to Oct 3, 1960 , that (I) (we) last saw the deceased alive on Sept 1960 , and that death occurred at 1:00 PM from the causes and on the date stated above.			
22a. SIGNATURE Herbert H. Leighton		22b. DATE SIGNED 5 Oct 60	
22c. PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D.		22d. ADDRESS Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/1960	
23c. NAME OF CEMETERY OR CREMATORY Underwood Cemetery		23d. LOCATION (City, town, or county) (State) near Oakland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H.C. Leighton		25a. REC'D BY REGISTRAR DATE OCT 6 '60	
ADDRESS Oakland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

bp

11523

CERTIFICATE OF DEATH

11523

State of New York, County of New York, City of New York.

I, the undersigned, a duly qualified and licensed physician, do hereby certify that

the within and foregoing is a true and correct statement of the facts and circumstances

surrounding the death of the person named above, and that the same was caused by

the disease or diseases, injuries or injuries, and causes stated above, and that the

same were the direct and proximate cause of death.

Witness my hand and the seal of my office, this _____ day of _____, 19____.

Physician

Medical Examiner

Coroner

Registrar

Clerk

Witness

Witness

Witness

Witness

Witness

Witness

<div style="display: flex; justify-content: space-between;"> 11420 MARYLAND STATE DEPARTMENT OF HEALTH 11402 </div> <div style="text-align: center;"> DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND			c. LENGTH OF STAY IN 1b 8 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT CO. MEMORIAL HOSPITAL					d. STREET ADDRESS 18 ALDER STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SANDRA JANE BRAY					4. DATE OF DEATH OCTOBER 10 19 60				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 13, 1940		9. AGE (In years last birthday) 19 yrs.	
						IF UNDER 1 YEAR Months 10 Days 27		IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) BRUCETON MILLS, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FLOYD MARSHALL COLLINS					14. MOTHER'S MAIDEN NAME LUCY ELIZABETH COPEMAN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-38-0116		17. INFORMANT (H) ROGER WAYNE BRAY OAKLAND, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myelogenous leukemia DUE TO (c) </p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH 30 hrs. 30 days. </p> </div> </div>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 18 Alder St.									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 20 Sept 19 60 to 10 Oct 19 60 that (I) last saw the deceased alive on 10 Oct 19 60 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.									
22a. SIGNATURE B. L. Grant M.D.					22b. DATE SIGNED OCT 17 '60				
22c. PHYSICIAN'S NAME (Type) B. L. GRANT M. D.					22d. ADDRESS OAKLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/12/60		23c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		23d. LOCATION (City, town, or county) (State) Deer Park Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home					ADDRESS Oakland, Maryland				
25a. REC'D BY REGISTRAR OCT 17 '60					25b. REGISTRAR'S SIGNATURE Arthur L. Thomas				

MEDICAL CERTIFICATION

1

070

M

1195

CERTIFICATE OF DEATH

1195

MADE IN THE UNITED STATES OF AMERICA
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
BUREAU OF VITAL STATISTICS

1. NAME OF DECEASED: _____
2. SEX: _____
3. AGE: _____
4. DATE OF BIRTH: _____
5. PLACE OF BIRTH: _____
6. DATE OF DEATH: _____
7. PLACE OF DEATH: _____
8. CAUSE OF DEATH: _____
9. MANNER OF DEATH: _____
10. SIGNATURE OF DECEASED: _____
11. SIGNATURE OF WITNESS: _____
12. SIGNATURE OF PHYSICIAN: _____
13. SIGNATURE OF CLERK: _____
14. SIGNATURE OF REGISTRAR: _____
15. SIGNATURE OF JUDGE: _____
16. SIGNATURE OF SHERIFF: _____
17. SIGNATURE OF TOWNSHIP CLERK: _____
18. SIGNATURE OF COUNTY CLERK: _____
19. SIGNATURE OF STATE CLERK: _____
20. SIGNATURE OF NATIONAL CLERK: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11421

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11493

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Grant		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 6 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Petersburg,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppitt-Weeks Nursing Home			d. STREET ADDRESS ---		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Alice Middle C.. Last Crites			4. DATE OF DEATH Month October Day 6, Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1881		9. AGE (In years last birthday) yrs. 79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Richard Pennington			14. MOTHER'S MAIDEN NAME Margaret Mongold		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ----		17. INFORMANT Emma S. Hall Address Petersburg, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Oakland, Md.	
20f. (City or town) Oakland		(State) Md.			
21. I certify that (I) (this hospital) attended the deceased from OCT. 4 , 19 60 , to OCT. 6 , 19 60 , that (I) (we) lost the deceased alive on OCT. 5 , 19 60 , and that death occurred at 2:30 P. from the causes and on the date stated above.					
22a. SIGNATURE E. I. Baumgartner		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) E. I. Baumgartner, M.D.		22d. ADDRESS Oakland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/8/1960		23c. NAME OF CEMETERY OR CREMATORY DURGEON Scott Cemetery Durgeon, Hardy Co., W. Va.	
23d. LOCATION (City, town, or county) Oakland, Md.		(State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Arnold Funeral Home		ADDRESS Petersburg, W. Va.		25a. REC'D BY REGISTRAR DATE OCT 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. House					

11421

CERTIFICATE OF DEATH

11421

Blank form with faint horizontal lines and some illegible text, likely a certificate of death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HOYES, MD.			c. LENGTH OF STAY IN 1b 72 YRS.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HOYES, MD.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 MILES NORTH OF HOYES MD.				d. STREET ADDRESS 2 MILES NORTH OF HOYES MD.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ARTHUR Last CUSTER				4. DATE OF DEATH Month OCTOBER Day 21 Year 1960					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 12, 1888		9. AGE (In years lost birthday) 72 yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			10b. KIND OF BUSINESS OR INDUSTRY OWNED FARM		11. BIRTHPLACE (State or foreign country) HOYES, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME EMMANUEL E. Custer				14. MOTHER'S MAIDEN NAME ELMA CUPPETT					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO.		16. SOCIAL SECURITY NO. 215 36 7771		17. INFORMANT Address HUBERT A. FRIEND HOYES MARYLAND					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Coronary artery disease DUE TO (c) Arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from November 1947 to 13 Oct. 1960 , that (I) (we) lost saw the deceased alive on 13 Oct. 1960 , and that death occurred at 10 A.M. from the causes and on the date stated above.									
22a. SIGNATURE A.E. Mance				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) A.E. MANCE, M.D.				22d. ADDRESS OAKLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/24/60		23c. NAME OF CEMETERY OR CREMATORY HOYES CEMETERY		23d. LOCATION (City, town, or county) (State) HOYES MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE Leighton				ADDRESS OAKLAND MD.		25a. REC'D BY REGISTRAR OCT 26 60		25b. REGISTRAR'S SIGNATURE Arthur S. Friend	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

11422

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11405

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ++ Maryland b. COUNTY Allegany ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppert Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES LEWIS Middle DAVIS Last		4. DATE OF DEATH Month October Day 1 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 14, 1871
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY General Farming	
11. BIRTHPLACE (State or foreign country) Route 2, Wm's Road Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Davis		14. MOTHER'S MAIDEN NAME Louisa Gleichman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Russell Wentling		Address 518 Baltimore Avenue Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Intericerebral Sanguine (Rt foot) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 1956 to October 1960 , that (I) (we) last saw the deceased alive on Sept 27 1960 , and that death occurred on 10/1/60 from the causes and on the date stated above.			
22a. SIGNATURE E. J. BAUMGARTNER		22b. DATE SIGNED 10/1/60	
22c. PHYSICIAN'S NAME (Type) E. J. BAUMGARTNER		22d. ADDRESS 25 ALDEN ST - OAKLAND MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 3, 1960	
23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		23d. LOCATION (City, town, or county) (State) Allegany County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE OCT 5 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Haas			

1145

1145

CONTRACT OF SALE

THIS CONTRACT OF SALE is made this 1st day of January, 1911, between

JOHN J. HARRIS, of the County of ... State of ...

and

JOHN J. HARRIS, of the County of ... State of ...

for and to the use of

JOHN J. HARRIS, of the County of ... State of ...

JOHN J. HARRIS, of the County of ... State of ...

JOHN J. HARRIS, of the County of ... State of ...

JOHN J. HARRIS, of the County of ... State of ...

JOHN J. HARRIS, of the County of ... State of ...



JOHN J. HARRIS, of the County of ... State of ...

JOHN J. HARRIS, of the County of ... State of ...

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JOHN J. HARRIS, of the County of ... State of ...

JOHN J. HARRIS, of the County of ... State of ...

JOHN J. HARRIS, of the County of ... State of ...

JOHN J. HARRIS, of the County of ... State of ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11431 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11406
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PA</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL GRANTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CONFLUENCE PA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>536 HUGART 75X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>MERLE</u> Middle <u>HAROLD</u> Last <u>GRIFFITH</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 4, 1902</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RURAL MAIL CARRIER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. P.O.</u>	
11. BIRTHPLACE (State or foreign country) <u>MILL RUN, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WALTER GRIFFITH</u>		14. MOTHER'S MAIDEN NAME <u>NANCY GREEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>174-16-1890</u>	
17. INFORMANT <u>Mrs. Chloren Griffith, Confluence, Pa.</u>		Address <u>Confluence, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Transection of Cervical Cord; Fractured</u> DUE TO <u>Atlas; Ruptured Aorta</u> Conditions, if any, which gave rise to immediate cause (b) <u>Run over by automobile</u> (c) <u> </u> DUE TO <u> </u> DUE TO <u> </u> cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 Min.</u> <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> <u>Hit by automobile</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7:45</u> a. m. <u> </u> p. m. <u> </u> Oct. <u>19</u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt. # 40 West of Grantsville, Garrett, Md.</u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>		DATE SIGNED <u>October 19, 1960</u>	
EXAMINER'S NAME (Type) <u>JAMES H. FEASTER, Jr. M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/23/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ADDISON</u>		22d. LOCATION (City, town, or county) (State) <u>ADDISON, SOMERSET Co PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don J. Newman, Grantsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 26 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1143

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		SINGLE		MARRIED	
1234 E. BALTIMORE ST.		CLOCK REPAIRER		HIGH SCHOOL		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		INJURY	
JAN 15, 1925		HOME		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		NONE	
TIME OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATION		CONSCIOUSNESS	
10:30 AM		98.6		60		120/80		18		ALERT	
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE		COUNTY		STATE	
J. H. HARRIS		M.D.		JAN 15, 1925		BALTIMORE		BALTIMORE		MD.	
SIGNATURE OF NEXT OF KIN		RELATIONSHIP		DATE		PLACE		COUNTY		STATE	
J. H. HARRIS		WIFE		JAN 15, 1925		BALTIMORE		BALTIMORE		MD.	
SIGNATURE OF WITNESSES		RELATIONSHIP		DATE		PLACE		COUNTY		STATE	
J. H. HARRIS		FRIEND		JAN 15, 1925		BALTIMORE		BALTIMORE		MD.	
J. H. HARRIS		FRIEND		JAN 15, 1925		BALTIMORE		BALTIMORE		MD.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11432 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **11407**

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Star Route Oakland		c. LENGTH OF STAY IN 1b unk.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McHenry			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Frank First Carl Middle King Last				4. DATE OF DEATH Month 10 Day 1 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH April 28, 1917		9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) odd jobs		10b. KIND OF BUSINESS OR INDUSTRY miscellaneous		11. BIRTHPLACE (State or foreign country) Charleroi, Penna.			
13. FATHER'S NAME Fredrick King				14. MOTHER'S MAIDEN NAME Margaret (Mohr)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW 2		16. SOCIAL SECURITY NO. 211-07-8505		17. INFORMANT Address Wilbur King Charleroi, Penna.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet Wound Right Temporal 976 DUE TO Curry Skull Interval between onset and death Instant </div> <div style="width: 15%; text-align: center;"> Interval between onset and death </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shooting 22 rifle					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 10:10 p. m. 10/1/60		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) Room in W. 24 Drap Creek Rd Garrett Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE E. L. BAUMGARTNER		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (Acting)		DATE SIGNED 10/2/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/5/60		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery			
23. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich		ADDRESS Oakland, Maryland		24a. REC'D BY REGISTRAR DATE OCT 7 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Kiser				24c. LOCATION (City, town, or county) Oakland, Maryland (State)			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Medical Examiner's Office. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
1142 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH CERTIFICATE TO BE FILLED BY THE MEDICAL EXAMINER IN CASES OF SUICIDE, ACCIDENT, OR UNNATURAL DEATH IN CASES OF NATURAL DEATH, TO BE FILLED BY THE PHYSICIAN		NAME OF DECEASED LAST NAME FIRST MIDDLE SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE AGE <input type="text"/> YEARS <input type="text"/> MONTHS <input type="text"/> DAYS DATE OF BIRTH <input type="text"/>	
PLACE OF BIRTH STATE <input type="text"/> COUNTY <input type="text"/>		PLACE OF DEATH STATE <input type="text"/> COUNTY <input type="text"/>	
OCCUPATION <input type="text"/>		CAUSE OF DEATH <input type="text"/>	
MANNER OF DEATH <input type="checkbox"/> SUICIDE <input type="checkbox"/> ACCIDENT <input type="checkbox"/> UNNATURAL <input type="checkbox"/> NATURAL		MEDICAL HISTORY <input type="text"/>	
PRESENT ILLNESS <input type="text"/>		PREVIOUS ILLNESS <input type="text"/>	
PRESENT PHYSICAL CONDITION <input type="text"/>		PREVIOUS PHYSICAL CONDITION <input type="text"/>	
PRESENT MENTAL CONDITION <input type="text"/>		PREVIOUS MENTAL CONDITION <input type="text"/>	
PRESENT SOCIAL HISTORY <input type="text"/>		PREVIOUS SOCIAL HISTORY <input type="text"/>	
PRESENT FAMILY HISTORY <input type="text"/>		PREVIOUS FAMILY HISTORY <input type="text"/>	
PRESENT RACE <input type="text"/>		PREVIOUS RACE <input type="text"/>	
PRESENT RELIGION <input type="text"/>		PREVIOUS RELIGION <input type="text"/>	
PRESENT EDUCATION <input type="text"/>		PREVIOUS EDUCATION <input type="text"/>	
PRESENT OCCUPATION <input type="text"/>		PREVIOUS OCCUPATION <input type="text"/>	
PRESENT RESIDENCE <input type="text"/>		PREVIOUS RESIDENCE <input type="text"/>	
PRESENT MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		PREVIOUS MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	
PRESENT SEXUAL HISTORY <input type="text"/>		PREVIOUS SEXUAL HISTORY <input type="text"/>	
PRESENT SUBSTANCE ABUSE <input type="text"/>		PREVIOUS SUBSTANCE ABUSE <input type="text"/>	
PRESENT TREATMENT <input type="text"/>		PREVIOUS TREATMENT <input type="text"/>	
PRESENT HOSPITALIZATION <input type="text"/>		PREVIOUS HOSPITALIZATION <input type="text"/>	
PRESENT SURGERY <input type="text"/>		PREVIOUS SURGERY <input type="text"/>	
PRESENT MEDICATION <input type="text"/>		PREVIOUS MEDICATION <input type="text"/>	
PRESENT ALLERGIES <input type="text"/>		PREVIOUS ALLERGIES <input type="text"/>	
PRESENT VACCINATIONS <input type="text"/>		PREVIOUS VACCINATIONS <input type="text"/>	
PRESENT OTHER MEDICAL CONDITIONS <input type="text"/>		PREVIOUS OTHER MEDICAL CONDITIONS <input type="text"/>	
PRESENT PHYSICIAN <input type="text"/>		PREVIOUS PHYSICIAN <input type="text"/>	
PRESENT HOSPITAL <input type="text"/>		PREVIOUS HOSPITAL <input type="text"/>	
PRESENT DATE <input type="text"/>		PREVIOUS DATE <input type="text"/>	
PRESENT TIME <input type="text"/>		PREVIOUS TIME <input type="text"/>	
PRESENT SIGNATURE <input type="text"/>		PREVIOUS SIGNATURE <input type="text"/>	
PRESENT TITLE <input type="text"/>		PREVIOUS TITLE <input type="text"/>	
PRESENT ADDRESS <input type="text"/>		PREVIOUS ADDRESS <input type="text"/>	
PRESENT PHONE <input type="text"/>		PREVIOUS PHONE <input type="text"/>	
PRESENT FAX <input type="text"/>		PREVIOUS FAX <input type="text"/>	
PRESENT E-MAIL <input type="text"/>		PREVIOUS E-MAIL <input type="text"/>	
PRESENT WEBSITE <input type="text"/>		PREVIOUS WEBSITE <input type="text"/>	
PRESENT OTHER CONTACT INFORMATION <input type="text"/>		PREVIOUS OTHER CONTACT INFORMATION <input type="text"/>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11433

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MAY 1960
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11408

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND Rt#1		c. LENGTH OF STAY IN 1b 25 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Oakland.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 MILES SOUTH OF OAKLAND MD.				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HUBERT Middle MARTIN Last MARTIN				4. DATE OF DEATH Month OCTOBER Day 14 Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 26 1882		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) STREBY W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHRISTOPHER MARTIN				14. MOTHER'S MAIDEN NAME ANNA BURGESS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214 28 6681		17. INFORMANT Address Mrs. Emily Martin Rt#1 Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) generalized antherosclerotic disease. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 day UNK.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 27 Sep. 1960 to 14 Oct. 1960 , that (I) (we) last saw the deceased alive on 12 Oct 1960 , and that death occurred at 1:30 PM on the causes and on the date stated above.							
22a. SIGNATURE B. L. GRANT M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/15/60	
22c. PHYSICIAN'S NAME (Type) B. L. GRANT M.D.				22d. ADDRESS 3rd. St. OAKLAND Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/17/60		23c. NAME OF CEMETERY OR CREMATORY EGLON CEMETERY		23d. LOCATION (City, town, or county) (State) EGLON W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus				25a. REC'D BY REGISTRAR DATE OCT 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2411

RECEIVED

1943

M

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the funeral home. Give Page 5 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral home. Give Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
11434 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					11409					
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY Garrett MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller			c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) Robert Fredlock Pritts					4. DATE OF DEATH Month 10 Day 6 Year 1960					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 3, 1894		9. AGE (In years last birthday) 66 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal		11. BIRTHPLACE (State or foreign country) Elk Garden, W. Va.			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph Pritts					14. MOTHER'S MAIDEN NAME Ann Fredlock					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-16-5485		17. INFORMANT Robert K. Pritts, Kitzmiller, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND OF HEAD AND NECK DUE TO 976X Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF COLON INTERVAL BETWEEN ONSET AND DEATH 5 months										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with shot gun								
20c. TIME OF INJURY Month, Day, Year 10/6 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Kitzmiller Garrett MD				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE E. J. Baumgartner					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) E. J. BAUMGARTNER					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTING					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/9/60		22c. NAME OF CEMETERY OR CREMATORY Oakland Nethken Cem.			22d. LOCATION (City, town, or county) (State) Elk Garden, W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Therick F. Jones					ADDRESS Oakland, Maryland		24a. REC'D BY REGISTRAR OCT 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

DATE SIGNED

10/6/60

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH-DEATH-18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-18

1. NAME OF DECEASED JAMES H. SMITH		2. SEX Male	
3. AGE 45		4. RACE White	
5. DATE OF DEATH 11-18-1918		6. PLACE OF DEATH Home	
7. TIME OF DEATH 10:00 AM		8. CAUSE OF DEATH Pneumonia	
9. MANNER OF DEATH Natural		10. SIGNATURE OF EXAMINER J. H. Smith	
11. SIGNATURE OF WITNESSES J. H. Smith		12. SIGNATURE OF CORONER J. H. Smith	
13. SIGNATURE OF MINISTER J. H. Smith		14. SIGNATURE OF CLERGYMAN J. H. Smith	
15. SIGNATURE OF CHURCH J. H. Smith		16. SIGNATURE OF FUNERAL HOME J. H. Smith	
17. SIGNATURE OF BURIAL PLACE J. H. Smith		18. SIGNATURE OF INTERMENT J. H. Smith	
19. SIGNATURE OF CEMETERY J. H. Smith		20. SIGNATURE OF GRAVE J. H. Smith	
21. SIGNATURE OF MONUMENT J. H. Smith		22. SIGNATURE OF PLANTING J. H. Smith	
23. SIGNATURE OF FLOWERS J. H. Smith		24. SIGNATURE OF MUSIC J. H. Smith	
25. SIGNATURE OF PRAYER J. H. Smith		26. SIGNATURE OF BLESSING J. H. Smith	
27. SIGNATURE OF COMMENDATION J. H. Smith		28. SIGNATURE OF RECOMMENDATION J. H. Smith	
29. SIGNATURE OF EXHIBITION J. H. Smith		30. SIGNATURE OF RECORD J. H. Smith	
31. SIGNATURE OF INDEX J. H. Smith		32. SIGNATURE OF FILE J. H. Smith	
33. SIGNATURE OF SEARCH J. H. Smith		34. SIGNATURE OF RETURN J. H. Smith	
35. SIGNATURE OF DELIVERY J. H. Smith		36. SIGNATURE OF RECEIPT J. H. Smith	
37. SIGNATURE OF ACKNOWLEDGMENT J. H. Smith		38. SIGNATURE OF CLOSURE J. H. Smith	
39. SIGNATURE OF REMOVAL J. H. Smith		40. SIGNATURE OF DESTRUCTION J. H. Smith	
41. SIGNATURE OF REPAIR J. H. Smith		42. SIGNATURE OF RESTORATION J. H. Smith	
43. SIGNATURE OF PRESERVATION J. H. Smith		44. SIGNATURE OF PROTECTION J. H. Smith	
45. SIGNATURE OF MAINTENANCE J. H. Smith		46. SIGNATURE OF IMPROVEMENT J. H. Smith	
47. SIGNATURE OF MODIFICATION J. H. Smith		48. SIGNATURE OF ADJUSTMENT J. H. Smith	
49. SIGNATURE OF ALTERATION J. H. Smith		50. SIGNATURE OF TRANSFORMATION J. H. Smith	
51. SIGNATURE OF REFORMATION J. H. Smith		52. SIGNATURE OF REFORMATION J. H. Smith	
53. SIGNATURE OF REFORMATION J. H. Smith		54. SIGNATURE OF REFORMATION J. H. Smith	
55. SIGNATURE OF REFORMATION J. H. Smith		56. SIGNATURE OF REFORMATION J. H. Smith	
57. SIGNATURE OF REFORMATION J. H. Smith		58. SIGNATURE OF REFORMATION J. H. Smith	
59. SIGNATURE OF REFORMATION J. H. Smith		60. SIGNATURE OF REFORMATION J. H. Smith	
61. SIGNATURE OF REFORMATION J. H. Smith		62. SIGNATURE OF REFORMATION J. H. Smith	
63. SIGNATURE OF REFORMATION J. H. Smith		64. SIGNATURE OF REFORMATION J. H. Smith	
65. SIGNATURE OF REFORMATION J. H. Smith		66. SIGNATURE OF REFORMATION J. H. Smith	
67. SIGNATURE OF REFORMATION J. H. Smith		68. SIGNATURE OF REFORMATION J. H. Smith	
69. SIGNATURE OF REFORMATION J. H. Smith		70. SIGNATURE OF REFORMATION J. H. Smith	
71. SIGNATURE OF REFORMATION J. H. Smith		72. SIGNATURE OF REFORMATION J. H. Smith	
73. SIGNATURE OF REFORMATION J. H. Smith		74. SIGNATURE OF REFORMATION J. H. Smith	
75. SIGNATURE OF REFORMATION J. H. Smith		76. SIGNATURE OF REFORMATION J. H. Smith	
77. SIGNATURE OF REFORMATION J. H. Smith		78. SIGNATURE OF REFORMATION J. H. Smith	
79. SIGNATURE OF REFORMATION J. H. Smith		80. SIGNATURE OF REFORMATION J. H. Smith	
81. SIGNATURE OF REFORMATION J. H. Smith		82. SIGNATURE OF REFORMATION J. H. Smith	
83. SIGNATURE OF REFORMATION J. H. Smith		84. SIGNATURE OF REFORMATION J. H. Smith	
85. SIGNATURE OF REFORMATION J. H. Smith		86. SIGNATURE OF REFORMATION J. H. Smith	
87. SIGNATURE OF REFORMATION J. H. Smith		88. SIGNATURE OF REFORMATION J. H. Smith	
89. SIGNATURE OF REFORMATION J. H. Smith		90. SIGNATURE OF REFORMATION J. H. Smith	
91. SIGNATURE OF REFORMATION J. H. Smith		92. SIGNATURE OF REFORMATION J. H. Smith	
93. SIGNATURE OF REFORMATION J. H. Smith		94. SIGNATURE OF REFORMATION J. H. Smith	
95. SIGNATURE OF REFORMATION J. H. Smith		96. SIGNATURE OF REFORMATION J. H. Smith	
97. SIGNATURE OF REFORMATION J. H. Smith		98. SIGNATURE OF REFORMATION J. H. Smith	
99. SIGNATURE OF REFORMATION J. H. Smith		100. SIGNATURE OF REFORMATION J. H. Smith	

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11-18-1918

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11435

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11410

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MD b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE, MD			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELMER Middle D. Last SCHROCK				4. DATE OF DEATH Month OCT. Day 2 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 3 1899	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY SEMI-RETIRED		11. BIRTHPLACE (State or foreign country) BEALETON VA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL SCHROCK			14. MOTHER'S MAIDEN NAME AMANDA YODER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Raymond Schrock Address Grantsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. L. BAUMGARTNER		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/2/60			
EXAMINER'S NAME (Type) E. L. BAUMGARTNER		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTING			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/6/60	22c. NAME OF CEMETERY OR CREMATORY MAPLE VIEW		22d. LOCATION (City, town, or county) (State) WEST SALISBURY SUMMIT CO. PA			
23. FUNERAL DIRECTOR'S SIGNATURE Gen Hewman ADDRESS Grantsville, Md.		24a. REC'D BY REGISTRAR DATE OCT 7 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Hines				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON, 19

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11423

11411
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William Elisha Stevens				4. DATE OF DEATH 10 5 19 60				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1916		
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) welder			10b. KIND OF BUSINESS OR INDUSTRY Coal		11. BIRTHPLACE (State or foreign country) Taylor Co., W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Milton G. Stevens				14. MOTHER'S MAIDEN NAME Verla Phillips				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. /		17. INFORMANT Lester M. Stevens Grafton, W. Va.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 451X IMMEDIATE CAUSE (a) INTRAPERICARDIAL HEMORRHAGE, MASSIVE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RUPTURE OF DISSECTING ANEURYSM OF AORTA DUE TO (c) 5-10 Min.						INTERVAL BETWEEN ONSET AND DEATH 5-10 Min.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
22a. BURIAL, CREMATION, REMOVAL (Specify) burial				22b. DATE THEREOF 10/8/60		22c. NAME OF CEMETERY OR CREMATORY Bluemont Cemetery		
22d. LOCATION (City, town, or county) (State) Grafton, W. Va.								
23. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich				ADDRESS Oakland, Maryland		24a. REC'D BY REGISTRAR OCT 10 '60		
24b. REGISTRAR'S SIGNATURE Colton S. F...								

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
ISM 9/59

11424

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11412

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VICTOR Middle A. Last STOCKMAN		4. DATE OF DEATH Month OCTOBER Day 7 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 17, 1872
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min. 88	IF UNDER 24 HRS. Months 88 Days 88 Hours 88 Min. 88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SYLVESTER STOCKMAN		14. MOTHER'S MAIDEN NAME JANE KELLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ED. P. STOCKMAN	
17. INFORMANT ROUTE #2 OAKLAND, MD.		Address ROUTE #2 OAKLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Arteriosclerotic Cardio-vascular Disease 57 yrs Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Arteriosclerosis DUE TO 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from FEB. 12, 19 55 to OCT. 7, 19 60 , that (I) (we) last saw the deceased alive on OCT. 7, 19 60 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Andrew E. Mance		22b. DATE SIGNED 8 Oct 60	
22c. PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.		22d. ADDRESS THIRD STREET - OAKLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 10/9/60		23b. DATE THEREOF 10/9/60	
23c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery		23d. LOCATION (City, town, or county) (State) Terra Alta, West Virginia.	
24. FUNERAL DIRECTOR'S SIGNATURE R. R. Watson		25a. REC'D BY REGISTRAR Arthur E. Kraus	
ADDRESS Terra Alta, West Virginia		25b. REGISTRAR'S SIGNATURE Arthur E. Kraus	
Md FD License A8305		DATE OCT 13 '60	

11211

CERTIFICATE OF MARRIAGE

11211

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11211

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11425

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11413

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Lancaster	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, RD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morgantown	
c. LENGTH OF STAY IN 1b 2 1/2 Yrs.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Catherine First Stoltzfus Middle Stoltzfus Last		4. DATE OF DEATH October, 11 Month 11 Day 1960 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October, 31 1870
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR 11 Months 11 Days 11 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housemaid		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Simeon Stoltzfus		14. MOTHER'S MAIDEN NAME Sarah Esch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Jonas Stoltzfus Address Gortner, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Arteriosclerotic Cardio-Vascular Disease DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1959 to Oct 1960 , that (I) (we) lost saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Herbert H. Leighton M.D.		22b. DATE SIGNED 11 Oct 60	
22c. PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D.		22d. ADDRESS 77 Oak Street, Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10, 14, 60.	
23c. NAME OF CEMETERY OR CREMATORY Millwood		23d. LOCATION (City, town, or county) (State) Gap, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE John Whitehead ADDRESS Oakland, Md.		25a. REC'D BY REGISTRAR Arthur L. Kraus DATE OCT 14 '60	
25b. REGISTRAR'S SIGNATURE			

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STATE OF TEXAS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11436

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11415

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mt. Lake Park				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) River 1/2 Mile east of Town				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Claude Earnest Twigg				4. DATE OF DEATH Month Day Year Oct. 14, 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 1897		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Washer		10b. KIND OF BUSINESS OR INDUSTRY Used Car Lot		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Levin Twigg				14. MOTHER'S MAIDEN NAME Orlena Nicely			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-1166		17. INFORMANT Address Mr. Curtis Twigg Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3-5 Min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Also slashed wrists and neck							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Suicide in stream					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 10:00 p.m. Oct. 14 1960		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mt. Lake Park		20f. (City or town) (County) (State) Near Oakland, Garrett, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster Jr.</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James H. Feaster Jr. M.d.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct. 17, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-1960		22c. NAME OF CEMETERY OR CREMATORY Mt. Labor Cem.		22d. LOCATION (City, town, or county) (State) East Of Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles L. George Cumberland, Md.				24a. REC'D BY REGISTRAR OCT 18 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

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11426 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11416

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KITZMILLER - Md. (Post office)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS Potomac Manor, W. Va.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BESSIE Middle IRENE Last WILKINS				4. DATE OF DEATH Month OCTOBER Day 27 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 30, 1887	
9. AGE (In years last birthday) 73 yrs.		10. AGE (In years last birthday) 73 yrs.		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME Jacob Kuhn				14. MOTHER'S MAIDEN NAME Ellen Albright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, unknown) no				16. SOCIAL SECURITY NO. None		17. INFORMANT (HUSBAND) ANGUS MACKER WILKINS KITZMILLER, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 3 days 4-6 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 10/24/60 to 10/27/60 , that (I) (we) last saw the deceased alive on 10/27/60 and that death occurred at 4:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE A. E. Mance M.D.				22b. DATE SIGNED 27 Oct 60			
22c. PHYSICIAN'S NAME (Type) DR. A. E. MANCE				22d. ADDRESS OAKLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/30/60		23c. NAME OF CEMETERY OR CREMATORY BLOOMINGTON		23d. LOCATION (City, town, or county) (State) BLOOMINGTON, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Amy M. Sharpless				ADDRESS Blaine, W. Va.		25a. REC'D BY REGISTRAR NOV 1 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Knecht	

11418

11418

RECEIVED

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CERTIFICATE OF DEATH

11417

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland				c. LENGTH OF STAY IN 1b 69 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS X Rural Oakland, Rt. 2			
3. NAME OF DECEASED (Type or print) First Middle Last Hervey Wakeman Wolfe				4. DATE OF DEATH Month Day Year Oct. 18 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1891	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Marcellus Wolfe				14. MOTHER'S MAIDEN NAME Neoma Fike			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-38-0084		17. INFORMANT Address Mrs. Nellie Wolfe Oakland, Md. Rt. 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH Sudden 2 years 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred on _____, 19____, from the causes and on the date stated above.							
ACTUAL SIGNATURE A. S. Maurice M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Oakland Md. 19 Oct 60			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 22, 1960		22c. NAME OF CEMETERY OR CREMATORY Wolfe Family		22d. LOCATION (City, town, or county) (State) Oakland Rt. 2 Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wayne C. Spizzle Davis, W.Va.				24a. REC'D BY REGISTRAR DATE OCT 26 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

CERTIFICATE OF DEATH

11437

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 68		DATE OF BIRTH 1881		PLACE OF BIRTH Maryland	
MARRIAGE Married		EDUCATION High School		OCCUPATION Retired		RELIGION Roman Catholic		RACE White	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		DATE OF DEATH 1949		PLACE OF DEATH Home		CITY OF DEATH Baltimore	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF FUNERAL HOME J. H. Harris		SIGNATURE OF WITNESS J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF NEXT OF KIN J. H. Harris	
DATE OF DEATH 1949		PLACE OF DEATH Home		CITY OF DEATH Baltimore		STATE OF DEATH Maryland		COUNTY OF DEATH Baltimore	
NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 68		DATE OF BIRTH 1881		PLACE OF BIRTH Maryland	
MARRIAGE Married		EDUCATION High School		OCCUPATION Retired		RELIGION Roman Catholic		RACE White	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		DATE OF DEATH 1949		PLACE OF DEATH Home		CITY OF DEATH Baltimore	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF FUNERAL HOME J. H. Harris		SIGNATURE OF WITNESS J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF NEXT OF KIN J. H. Harris	
DATE OF DEATH 1949		PLACE OF DEATH Home		CITY OF DEATH Baltimore		STATE OF DEATH Maryland		COUNTY OF DEATH Baltimore	

11437

For information of the public, it is hereby stated that the above is a true and correct copy of the original record as the same appears in the files of the State Department of Health, Baltimore, Maryland, and that the same is a true and correct copy of the original record as the same appears in the files of the State Department of Health, Baltimore, Maryland.